Intake Form Template for New Clients

Practice Name: _____

Practice Address _____

Practice Phone Number: _____ Email: _____

Basic Information

First and Last Name (Legal): _____

What name or term would you like me to use to address you? _____

Address: _____

Date of Birth and Age: _____

Phone Number: _____ Email: _____

Pronouns: _____

Gender Identity (Optional) _____

Preferred Language(s): _____

Emergency Contact

First and Last Name: _____

Phone Number: _____ Email: _____

Do you have any accessibility needs for our sessions? _____

Presenting Concerns

What are you seeking therapy for?

When did this problem first start?

What areas of your life have been most affected because of this problem?

Are you currently experiencing any thoughts of self harm or suicide?

Are you currently experiencing any other crisis?

Therapy Goals

If you could accomplish one thing in therapy, what would it be?

What are your short-term goals/needs for therapy?

What are your long-term goals/needs for therapy?

Medical and Biological History

Do you have any medical conditions, hospitalizations, or chronic illnesses? If so, please describe:

Current Medications

Medication Name: _____

Dosage: _____

Frequency: _____

Prescribing Doctor: _____

Purpose/Condition Being Treated: _____

How long have you been taking this medication?: _____

Have you noticed any side effects? If so, please describe:

Do you feel your current psychiatric medications (if applicable) are effective?

- Yes
- No
- Not Sure

Please explain: _____

Previous Medications

Have you taken any psychiatric medications in the past?

- Yes
- No

If yes, please list them:

Medication Name: _____

Dosage: _____

Frequency: _____

Prescribing Doctor: _____

Purpose/Condition Treated: _____

Duration of Use: _____

Reason for Discontinuation: _____

Medication Management

Do you have any difficulties in managing your medications (e.g., remembering to take them, accessing refills, affordability)?

Yes

No

If yes, please describe: _____

Medication Effects and Monitoring

Have you had any recent changes in your medications (e.g., new medications, changes in dosage)?

Yes

No

If yes, please describe: _____

Do you feel your current medications are effective?

Yes

No

Not Sure

Please explain: _____

Exercise and Physical Activity

How would you rate your overall physical health?

Excellent

Good

Fair

Poor

How often do you engage in physical activity or exercise?

Daily

Several times a week

Weekly

Rarely

Never

What types of physical activities do you enjoy?: _____

Diet and Nutrition

How would you describe your eating habits?

- Balanced and healthy
- Somewhat healthy
- Unhealthy

Sleep

On average, how many hours of sleep do you get per night?:_____

Do you have any difficulties with sleep (e.g., falling asleep, staying asleep, nightmares)?

- Yes
- No

If yes, please describe: _____

Mental Health History

How would you rate your overall mental health?

- Excellent
- Good
- Fair
- Poor

Have you previously received any type of mental health services? If yes, please describe the services received, dates of treatment, and reason for treatment.

Have you ever been diagnosed with a mental health condition? If yes, please specify:

Do you have any history of self-harm, suicidal thoughts or thoughts of harm towards other?

Have you ever attempted suicide?

Have you experienced any trauma or loss?

Substance Use

Do you use any substances (e.g., alcohol, tobacco, recreational drugs)?

Yes

No

If yes, please specify: _____

How often do you use these substances?:

Have you ever felt that you should cut down on your use of these substances?

Yes

No

Has anyone ever expressed concern about your use of these substances?

Yes

No

Family Mental Health History

Has anyone in your family ever had any mental health concerns including substance use and addiction? (Grandparents, parents, siblings, etc.)

Are you aware of anyone in your family that has either attempted or died by suicide?

Is there a family history of medical conditions (e.g., heart disease, diabetes)? If yes, please specify:

Social History

What is your current living situation?

Who do you live with?

What is your current employment status?

Employed full-time

Employed part-time
Unemployed
Student
Retired
Other (please specify): _____

How do you feel about your current job or career?
Very satisfied
Satisfied
Neutral
Dissatisfied
Very dissatisfied
Details (Optional): _____

Do you have any cultural or spiritual practices, beliefs, or traditions that are important to you? If yes, how can we best support them in therapy?

Do you have any military background?

What is your highest level of education?

Do you have any learning challenges?

Important Relationships

Are there any significant relationships in your life that you would like me to know about? This could include partners, close friends, or others who are important to you.

Overall, how would you rate the quality of these relationships?
Very satisfied
Satisfied
Neutral
Dissatisfied
Very dissatisfied

Are there any important relationships that you would like to discuss?

Coping Skills and Stress Management

How do you typically cope with stress or difficult situations?

Environmental Factors

Do you feel safe in your current living situation?

Yes

No

If no, please describe: _____

Do you have access to reliable transportation?

Yes

No

Are there any current financial or housing challenges?

Have you experienced challenges accessing enough food in the past month?

Are you currently experiencing any legal challenges? (Ex. Court, divorce, probation, etc.)

Insurance Information

Name of Insurance Company: _____

Policy Number: _____

Group Number: _____

Insurance Company Phone Number: _____

Insurance Company Address: _____

Policyholder's Name (if different from client): _____

Policyholder's Date of Birth: _____

Policyholder's Relationship to Client: _____

Policyholder's Employer (if applicable): _____

Secondary Insurance Information (if applicable)

Insurance Verification

Does your insurance plan require pre-authorization for therapy sessions?

- Yes
- No
- Not Sure

Is there a deductible that needs to be met before your insurance covers therapy sessions?

- Yes (Amount: _____)
- No
- Not Sure

What is your co-payment amount for each therapy session?: _____

Is there a limit to the number of therapy sessions covered by your insurance per year?

- Yes (Number of Sessions: _____)
- No
- Not Sure

Have you utilized any therapy sessions covered by your insurance this year?

- Yes (Number of Sessions Used: _____)
- No
- Not Sure

Do you have an out-of-pocket maximum for your insurance plan?

- Yes (Amount: _____)
- No
- Not Sure

Insurance Authorization and Release

I authorize the release of any medical or other information necessary to process insurance claims.

Client Signature: _____

Date: _____

I authorize payment of medical benefits to the provider of services.

Payment Information

Primary Payment Method

Name on Card: _____

Card Number: _____

Card Expiration Date: _____

Three-Digit Security Code on Card: _____

Backup Payment

Name on Card: _____

Card Number: _____

Card Expiration Date: _____

Three-Digit Security Code on Card: _____

Sign: _____

Print Full Name: _____

Date: _____